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Harmful and Helpful Therapy Practices with Consensually Non-Monogamous Clients: Toward an Inclusive Framework

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Abstract

Objective: Drawing on minority stress perspectives, we investigated the therapy experiences of individuals in consensually non-monogamous (CNM) relationships. **Method:** We recruited a community sample of 249 individuals engaged in CNM relationships across the U.S. and Canada. Confirmatory factor analysis structural equation modeling were used to analyze client perceptions of therapist practices in a number of *exemplary* practices (affirming of CNM) or *inappropriate* practices (biased, inadequate, or not affirming of CNM), and their associations with evaluations of therapy. Open-end responses about what clients found *very helpful* and *very unhelpful* were also analyzed. **Results:** Exemplary and inappropriate practices constituted separate, but related patterns of therapist conduct. As expected, perceptions of exemplary and inappropriate practices predicted therapist helpfulness ratings and whether participants prematurely terminated their therapeutic relationships. Qualitative results point toward the importance of having/pursuing knowledge about CNM and using affirming, nonjudgmental practices. **Conclusions:** Therapists are positioned to either combat or perpetuate the minority stress faced by individuals engaged in CNM. The results of this study highlight the need for additional research, training, and guidelines regarding CNM clients and their therapy experiences.

Keywords: consensual non-monogamy, minority stress, therapy, sexuality

Public Health Significance Statement

This study highlights how certain therapist practices relate to the experiences of clients who are in consensually non-monogamous (CNM) relationships. The results identify practices that are perceived as generally helpful or unhelpful, and point to the need for additional research, training, and guidelines to bridge therapists' knowledge gap regarding CNM.

Harmful and helpful therapy practices with consensually non-monogamous clients: Toward an inclusive framework

Public interest—and participation—in consensual non-monogamy (CNM) or, relationship arrangements in which the all partners involved agree to extradyadic sexual and/or romantic relationships), are on the rise. This is evidenced by media coverage (e.g., *CNN*, *Scientific American*, *New York Times*), increased scientific inquiry (see Conley, Matsick, Valentine, Moors, & Ziegler, 2017; Conley, Ziegler, Moors, Matsick, & Valentine, 2013; Rubel & Bogaert, 2015, for reviews), popular books (e.g., Sheff, 2015; Veaux & Rickert, 2014), and elevating rates of Internet searches (Moors, 2017). In the field of psychology, Division 44 of the American Psychological Association also recently approved the first Consensual Non-Monogamy Task Force to promote awareness and inclusivity about CNM relationships.

The number of people who have or currently are engaged in CNM relationships is also not as small as one might expect. Twenty-two percent of Americans have been involved in a CNM relationship at *some point during their life* (Haupert, Gesselman, Moors, Fisher, & Garcia, 2017; Haupert, Moors, Gesselman, & Garcia, 2017) with approximately 4-5% *currently* engaged in a CNM relationship (Levine, Herbenick, Martinez, Fu, & Dodge, 2018; Rubin, Moors, Matsick, Ziegler, & Conley, 2014). Despite the prevalence and increasing public discourse on CNM relationships, U.S. culture still strongly privileges monogamous relationships in a number of ways—both subtle and overt—and frequently fails to acknowledge consensual multi-partner relationships (Moors & Schechinger, 2014). CNM relationships, for example, are stigmatized as promoting a host of negative outcomes (from relationship dissatisfaction to spreading sexually transmitted infections), and individuals in CNM relationships are viewed as possessing numerous undesirable qualities (in comparison to monogamous relationships; Conley, Moors, Matsick, &

Ziegler, 2013; Grunt-Mejer & Campbell, 2016; Moors, Matsick, Ziegler, Rubin, & Conley, 2013; Thompson, Bagley, & Moore, 2018). However, a small but growing body of empirical evidence suggests the contrary and also supports the notion that CNM relationships are equally viable options to monogamy (see Brewster et al., 2017; Conley, Matsick, Moors, & Ziegler, 2017; Moors, Matsick, & Schechinger, 2017; Rubel & Bogaert, 2015 for reviews and meta-analyses). Across several studies, researchers have found that people engaged in CNM and monogamy report similar levels of satisfaction, trust, commitment, and mental stability (e.g., Conley et al., 2017; Rubel & Bogaert, 2015).

Mental health professionals have historically played a critical role in providing support for marginalized populations, but without adequate education and training, they are subject to holding CNM-stigmatizing attitudes, and (unintentionally) use biased, inappropriate, or harmful practices with their CNM clients. To date, there is a dearth of research on the therapeutic experiences of CNM clients, and limited resources to guide clinical practice (see Graham, 2014; Weitzman, 2006; and Weitzman, Davidson, & Phillips, 2012). We therefore aimed to conduct the first systemic investigation of CNM client reports of therapist practices.

CNM and Sexual Minority Communities

The movement that started with promoting the rights of individuals identifying as gay or lesbian has become increasingly more mobilized, visible, and vocal about issues of equality. The larger sexual minority community has come to include additional sub-cultures, such as the bisexual, gender non-confirming, trans*, queer, intersex, asexual, alt-sex, dominant-submissive sex, kink, and consensual non-monogamy communities (Nichols & Shernoff, 2007). There are clear and distinct differences that make each community unique, as well overlapping experiences that broadly shared between these sub-cultures (e.g., societal stigma, general minority stress).

Consensual non-monogamy (and critiques of compulsory monogamy) has been found to resonate broadly in many non-conforming cultures, including feminist, leftist, lesbian, gay, bisexual, transgender, BDSM and queer activists (Klesse, 2011). Yet, how to conceptualize CNM as well as how it fits within the sexual minority community is largely unchartered empirical and legal territory.

Scholars have discussed the biological, psychological, and social influences shaping whether CNM should be considered a sexual orientation (Tweedy, 2011; Klesse, 2014), relationship practice (Lano and Parry Lano, 1995), theory, (Emens, 2004), identity (Barker, 2005), or relationship orientation (Anapol, 2010). There are also diverse perspectives about whether, how, and/or when to include CNM in the larger LGBTQ community. According to Warner (1999), if there is a political divide, it is between those who emphasize inclusiveness and assimilation, and those who promote the importance of separatism and fostering differences.

Given the convergence in reported experiences between the CNM and other sexual minority communities (e.g., discrimination based on sexual identity/practices, coming out/visibility concerns), we broadly conceptualize individuals engaged in CNM as sexual minorities. As such, we draw on the body of sexual minority stress literature as a theoretical framework. Additional research is needed, however, to clarify specific points of convergence and divergence with other sexual minority populations. The terms used in this paper are not intended to endorse a particular position about how CNM should be conceptualized.

Minority Stress

Individuals from sexual minority groups are disproportionately exposed to discrimination, victimization, and rejection compared to heterosexual individuals (Balsam, Rothblum, & Beauchaine, 2005; Meyer, 2003). As a consequence, sexual minorities experience

additional mental health burdens (Cochran, 2001) and utilize mental health services more frequently than heterosexual individuals (Cochran, Sullivan, & Mays, 2003). This process, by which stigma and discrimination create a more hostile social environment leading to mental health problems, is known as *minority stress* (Meyer, 2003, see also DiPlacido, 1998). Hatzenbuehler (2009) posited that cognitive, affective, and interpersonal pathways mediate the relationship between exposure to minority stressors and mental health. These mechanisms emerge early in sexual minority individuals' lifetimes and lead to psychosocial vulnerabilities and mental health issues (Eisenberg & Resnick, 2006; Safren & Heimberg, 1999).

Minority stress is not necessarily exclusively negative, however. Resilience is also inherent aspect of minority stress theory, as the presence of stress also tends to bolster one's capacity to cope (Meyer, 2015). Minority stress theory thereby provides a framework for understanding how stigma experienced by people engaged in CNM may be linked with mental health issues, as well as resilience.

Therapeutic Alliances and CNM Minority Stress

Sexual minorities receiving counseling services have been found to experience numerous benefits, including forming a positive identity, learning the effects of stigma, and developing strategies for coping (Browning et al., 1991; Eubanks-Carter et al., 2005; Perez et al., 2000). Clinical research has also consistently demonstrated that safety in a therapeutic relationship is critical for positive change (Levitt & Williams, 2010). Mental health providers are uniquely positioned to help their clients feel safe by seeking to recognize and mitigate the effects of stigma experienced by their CNM clients. If a client does not feel safe or hold a secure bond with their therapist, they are more likely to prematurely terminate therapy, which has been found to dramatically reduce efficacy of therapeutic interventions (Heilbrun, 1982; Pekarik, 1992). In

light of this, many consider the therapeutic alliance—defined broadly as the collaborative and affective bond between therapist and client—an essential element of effective psychotherapy (Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000).

Therapists typically do not receive training on issues facing the CNM community (Weitzman, 2006) and available guidance is limited (e.g., McCoy, Stinson, Ross, & Hjelmstad, 2015). This leaves people engaged in CNM seeking mental health services tasked with finding culturally competent care within a mental health system that is not adequately prepared to address their concerns. Moreover, the dearth of CNM-related training renders therapists susceptible to causing harm to their clients (Mikalson, Pardo, & Green, 2012; Xavier et al., 2012), by creating or perpetuating minority stress, which could undermine their abilities to assist CNM clients. Therapists who are unaware of their own values and biases are susceptible to impeding progress in therapy (Corey, Schnieder-Corey, & Callanan, 1993). When same-sex attraction is viewed negatively, for example, therapists are more likely to view the client's sexual orientation as a poignant source of the client's psychological difficulties, even when it has not presented it as a problem (Garnets, Hancock, Cochran, Goodchilds, & Peplau., 1991; Liddle, 1996). We anticipate therapists' explicit or implicit negative attitudes and non-affirming practices can adversely impact treatment with CNM as it does with other sexual (and gender) minority populations, and that guidelines created for these populations (see American Psychological Association, 2012; American Psychological Association, 2015) may also be warranted to protect and adequately support CNM clients.

The Present Study

People engaged in CNM continue to face considerable prejudice and discrimination (Conley, Moors, et al., 2013; Cox, Fleckenstein, & Bergstrand, 2013; Hutzler, Giuliano,

Herselman, & Johnson, 2016). Though therapists can support people in CNM relationships, their ability to do so may hinge on using affirming practices to build a positive therapeutic relationships (cf. Corey, Schneider-Corey, & Callanan, 1993; Levitt & Williams, 2010). The current literature guiding therapy with individuals in CNM relationships relies on first-person experiences and small samples (e.g., Bairstow, 2016; Girard & Brownlee, 2015; Weitzman, 2006; Weitzman, Davidson, & Phillips, 2012; Zimmerman, 2012). To provide a broader understanding of therapist practices with CNM therapy clients, we designed the first mixed-method (quantitative and qualitative) study to systemically explore what CNM therapy clients' perceive to be helpful and unhelpful therapy practices.

In the present study, we examined CNM therapy client perceptions to pursue four empirical goals. We first determined an initial set of therapeutic practices that would likely affirm or compromise the therapeutic relationship between CNM clients and their therapists. Next, we estimated the frequency with which therapists engage in exemplary and inappropriate behaviors with their CNM clients. Then, we tested the association between the frequency of exemplary and inappropriate behaviors and therapeutic outcomes. Finally, we thematically coded open-ended responses to identify what therapeutic practices CNM clients found to be very helpful or unhelpful.

Method

Participants and Procedure

Volunteer participants engaged in CNM were recruited online via listservs, organizations, and social groups focused on CNM relationships (e.g., National Coalition of Sexual Freedom, reddit: polyamory) to take part in a 30-minute study about their relationship experiences. Participants were asked to indicate their age, gender, sexual orientation, race/ethnicity, and

relationship structure. While "monogamy" was included as a relationship structure option, none of our participants selected this option. Rather than specifically recruiting for people who were actively seeking mental health services, we minimized selection bias by obtaining a community sample of individuals engaged in CNM, and used a subsample of these individuals who had seen a therapist and indicated romantic relationship(s) was a topic of conversation in therapy. Thus, participants were eligible to take part in the present research if they were currently engaged in a CNM relationship, had discussed (their) romantic relationship with a therapist, and were at least 18 years old. The present study was approved by the first and third authors' Institutional Review Boards.

A strategy similar to that used by Liddle (1996) was incorporated in the present study. Specifically, participants were asked to describe their experiences with up to four different therapists: (a) their current/most recent therapist, (b) their first therapist, (c) their most helpful therapist, and (d) their worst or most harmful therapist. For each therapist, participants indicated whether their therapist engaged in a list of 13 observable practices/behaviors (i.e., "Please put the number '1' in each box if your therapist engaged in the corresponding practice."), rated how helpful their therapist was, and if they prematurely terminated because of a negative CNM-related interaction. Participants also provided open-ended responses and were asked to describe what their therapist(s) did (regarding their relationship orientation/structure) that they found to be (a) *very helpful*, as well as what they found to be (b) *very unhelpful*.

We focused on participants' reports of experiences with their most recent (or current) therapist, as a means of reducing recall bias. Of the 577 participants who completed the survey, 428 (74%) had at least one therapy session, and 249 (43%; our final sample) indicated that their romantic relationship(s) was/were a topic of conversation in therapy (see Table 1). Nine percent

of our participants indicated they had one to four sessions of counseling or psychotherapy, 30% had five to 20 sessions, and 61% had more than 20 sessions.

Measures

CNM therapeutic practices. In her pioneering work, Liddle (1996) distilled suggested practices for working with LGB clients offered by the American Psychological Association (APA; see Garnets et al., 1991) into thirteen items reflecting therapist behavior that could be observed by a client. These thirteen items reflected two subscales: *biased, inadequate, or inappropriate practices* and *exemplary practices*. For our investigation, the items created by Liddle (1996) were modified to apply to people engaged in CNM relationships (see Table 2). Language referring to sexual orientation (i.e., heterosexual, homosexual) was replaced to refer to relationship orientation/structure (i.e., monogamous, consensually non-monogamous). Further, we revised one of the exemplary practices items so it would not read as a double negative (i.e., "your therapist *never* made an issue of your sexual orientation when it was not relevant" was revised to "your therapist made an issue of your sexual orientation when it was not relevant"). As a result, the item became reflective of an inappropriate practice, rendering an *exemplary practices* subscale consisting of 3 items ($\alpha = .67$), and an *inappropriate practices* subscale consisting of 10 items ($\alpha = .79$). The modifications were initially made by two of the authors. Once the author's reached agreement, the modified scale was reviewed by six experts (two professors and four doctoral candidates) in the field of romantic relationship and sexuality science as well as several individuals engaged in the CNM community.

Therapist helpfulness. Following Liddle (1996), we assessed global therapist helpfulness using a single item (Brooks, 1981; 1 = *destructive; 4 = very helpful*). Using a single-item measure is a common practice to investigate client perceptions of therapy (e.g., Fridman,

2010; Fuller & Hill, 1985; Horvath, Marx, & Kamann, 1990), with face-valid items typically yielding high levels of predictive validity (Hoyt, 2002). Single-item measures of helpfulness are also known to be stable over time, consistent between clients and therapists, and predictive of session outcome measures (Hill et al., 1994). They are also commonly used as a treatment outcome (e.g., Hill, et al., 1994; Elliott, 1985; Liddle, 1996) and have been found to hold concurrent validity with clients' overall satisfaction with their therapist (Conte, Buckley, Picard, & Karasu's, 1994).

Premature termination. For each therapist, participants were asked to report (0 = *no*, 1 = *yes*) if they had terminated therapy because of a negative experience with their therapist that was based on their CNM relationship orientation/structure.

Data Analysis Strategy

Statistical analyses were conducted using *R* (*R* Core Team, 2016). We first calculated frequencies of the individual exemplary and inappropriate practices. We then used confirmatory factor analysis (CFA) and structural equation modeling (SEM) techniques (Beaujean, 2014; Brown, 2015; Little, 2013) in order to: (1) evaluate the latent structure of exemplary and inappropriate practices and (2) test the contributions of exemplary and inappropriate practices for predicting ratings of therapist helpfulness as well as premature termination of the therapeutic relationship. CFA and SEM models were fit using the *lavaan()* package (Rosseel, 2012), reliability of latent factors were estimated using the *semTools()* package (semTools Contributors, 2016), and plots were created using the *ggplot2()* package (Wickham, 2009).

Modeling the structure of individual exemplary and inappropriate practices. We fit 1- and 2-factor models to the individual practice items, in order to determine whether distinguishing between the two valences (i.e., exemplary and inappropriate) was necessary, or

rather, whether a singleton factor would be sufficient. We identified both models using a fixed-factor scale-setting approach (i.e., fixing latent variances to 1 and estimating all factor loadings) and used a robust categorical estimator (diagonal weighted least squares, DWLS), given the dichotomous nature of the practice items. We then evaluated the plausibility of both the 1-factor and 2-factor models by interpreting both an absolute (RMSEA) and relative (CFI) index of model fit (see Hu & Bentler, 1999), as well as using a scaled and adjusted likelihood ratio test (Satorra, 2000) in order to directly compare the fit of both models.

Recent simulation research on model fit indexes (see McNeish, An, & Hancock, 2018), however, has revealed that universal application of the Hu and Bentler cutoff values (1999; RMSEA <= .06, CFI >= .95) is not recommended, because these cutoffs biasedly penalize well-fitting models with highly reliable factors, while biasedly accommodating poor-fitting models with less reliable factors--a pattern termed the "reliability paradox" of model fit (Hancock & Mueller, 2011). Whereas the Hu and Bentler (1999) cutoff values are appropriate to apply to models with standardized factor loading values that are comparable to those specified in Hu and Bentler's (1999) simulations (*M* = .75), McNeish et al. (2018) argue that more appropriately liberal cutoff values ought to be used (e.g., RMSEA <= .20, CFI >= .775) when standardized loadings for a given model are higher than those specified in Hu and Bentler's (1999) simulation (e.g., *M* = .90). When appraising the fit of our specified models, we therefore report and interpret the level of measurement reliability, in order to determine reasonable cutoffs values.

Predicting therapist helpfulness and early termination from the use of exemplary and inappropriate practices. We fit a structural model in order to predict helpfulness scores as well as whether participants prematurely terminated their therapeutic relationship, using the latent factors of exemplary and inappropriate practice. Advantages of this SEM approach

include: (1) estimating larger effects with random error and measurement error removed from the true construct variance of the latent exemplary and inappropriate practice factors; and (2) simultaneously estimating two latent regression pathways in a single model, for predicting helpfulness scores (a continuous outcome) and premature termination (a categorical outcome). Effects for the dichotomous outcome of premature termination are probit-linked.

Thematic analysis of open-ended helpful and harmful therapy practices.

Participants' open-ended responses to the two questions asking if their therapist(s) did or said anything pertaining to their consensually non-monogamous relationship orientation/structure that they found to be "very helpful" or "very unhelpful" were analyzed with Braun and Clarke's (2006) epistemological approach to thematic analysis to identify the major and minor themes for each category. All responses were read through three times by the lead author, a psychology faculty member, and a trained psychology doctoral student. Each reader independently created a list of major and minor themes. The major and minor themes were then reviewed, discussed, and combined based on consensus. Each participants' responses were then coded as "1" if the theme if the theme was present, and "0" if the theme was not present by two reviewers with discrepancies decided by a third reviewer. The endorsements were then added (including the sum and percentages) for each of the major and minor themes.

Results

Frequencies of Exemplary and Inappropriate Practices

Rates of individual exemplary and inappropriate practices used by current/most recent therapists among people engaged in CNM relationships are presented in Figure 1. In terms of exemplary practices, a large majority people engaged in CNM perceived that their recent therapist was unafraid to address their relationship orientations when it was, in fact, relevant to

the issue(s) motivating them to seek services. A small majority of participants perceived their therapists as also helping them feel good about their CNM relationship orientation. However, only roughly one-third of recent therapists were described as quite knowledgeable of CNM communities and resources. Rates of recent therapists perceived as engaging in inappropriate practices were generally much lower, though many were described as presuming a monogamous orientation from their clients and lacking basic knowledge of CNM issues—the remaining inappropriate practices were experienced less frequently.

CFA of Exemplary and Inappropriate Practices

We then used CFA to determine whether distinguishing between exemplary and inappropriate practices was empirically supported. The 2-factor model yielded highly reliable factors (ω_3= 0.81) with standardized loadings values that were higher (M = .79, Mdn = .86) than those specified in Hu and Bentler's (1999) simulation (M = .75), suggesting that their recommended cutoff values would be overly conservative for appraising the fit of this model. We therefore determined that the fit of the 2-factor model was acceptable, as the relative index (CFI) and absolute index (RMSEA) were well within levels of model fit for more reliable factor solutions, as described by McNeish et al. (2018), χ^2 (64) = 229.75, p < .001, CFI = .93, RMSEA = .10 (90% CI: .09, .12). As expected, the factor for perceived exemplary practice was strongly and negatively correlated with factor for perceived inappropriate practice[1], r = -.78, p < .001.

[1] Unlike the exemplary practices (which are relatively homogenous in their factor loadings), the inappropriate practices varied in terms of their strength of association to the underlying latent Inappropriate Practice factor. An earlier IRT analysis (not described in detail here) revealed that constraining loadings to equality across inappropriate items lead to worsened fit (p < .001).

The single-factor solution was descriptively comparable to the two-factor solution in terms of relative and absolute fit, χ^2 (65) = 242.22, $p < .001$, CFI = .93, RMSEA = .11 (90% CI: .09, .12). However, a likelihood ratio test comparing these nested models revealed that the two-factor model of distinct, but strongly correlated perceptions of exemplary and inappropriate practices were better supported by the data, $\Delta\chi^2$ (1) = 11.78, $p < .001$ (see Table 2 for factor loadings).

SEM Predicting Therapist Helpfulness and Premature Termination

We then fit a structural equation model predicting ratings of therapist helpfulness as well as whether participants prematurely terminated their therapeutic relationship, using the latent exemplary and inappropriate practice factors. The full structural model fit the data acceptably well given the high degree of factor reliability, χ^2 (86) = 281.36, $p < .001$, CFI = .93, RMSEA = .10 (90% CI: .08, .11).

Taken together, perceptions of exemplary and inappropriate practice both significantly and uniquely contributed to the prediction of ratings of therapist helpfulness. Therapists who were perceived as using more exemplary practices were rated as more helpful, $b = 0.27$, $p = .02$, whereas therapists perceived as using more inappropriate practices were rated as less helpful, $b = -0.30$, $p = .001$. Moreover, therapists perceived as using a greater number of inappropriate practices were significantly more likely to have clients engaged in CNM prematurely terminate their therapeutic relationship, $b = 1.16$, $p < .001$; specifically, for every increase in one standardized latent unit of inappropriate practices, participants' probability of prematurely terminating increased by 87.60%. Exemplary practices were unassociated with premature termination rates, $b = 0.28$, $p = .34$.

We then performed an exploratory analysis of the moderating characteristics of participants' therapeutic experiences[2], to determine if they differed depending on whether participants searched for a therapist who was affirming toward CNM relationships (n = 114) or not (n = 135), as those who screened their therapist rated their therapist as more helpful (M = 3.61, SD = 0.63) than those who did not screen their therapist (M = 3.27, SD = 0.83), t (244.41) = -3.52, $p < .001$, d = 0.41. We began by testing whether our two-factor measurement model of exemplary and inappropriate therapeutic practices was invariant between these two screening groups, as invariance is a necessary precondition for validly comparing groups on structural portions of a model (see Vandenberg & Lance, 2000, for a review). We first fit a configurally invariant model, forcing the same general pattern of factors and loadings between groups, and evaluated its fit using the same criteria as our initial two-factor model (Hu & Bentler, 1999), while being mindful of the reliability paradox (McNeish et al., 2018). We then tested weak invariance (i.e., factor loading equivalency, necessary for valid between-group comparisons of latent correlations and regression paths) and strong invariance (i.e., intercept equivalency, necessary for valid between-group comparisons of latent means) by constraining parameter estimates to equivalence between groups and evaluating to what extent that degraded the fit of the model. Simulation research by Cheung and Rensvold (2002) suggests that traditional $\Delta\chi^2$ difference-tests are too liberal for rejecting invariance, and that examining differences in CFI between models is a more reasonable approach. They suggest that ΔCFI in excess of .01 suggests that a set of invariance constraints are untenable. Model fit indexes from our three levels of

[2] We thank an anonymous reviewer for the suggestion to consider moderators of our effects pertaining to other aspects of the therapeutic context.

invariance testing are presented in Table 3. In summary, all three levels of invariance appeared to be supported, thereby enabling us to proceed to comparing latent regression slopes and means between screening groups.

Screening moderated which types of practices were more strongly associated with ratings of helpfulness, as constraining slopes to equivalency between screening groups significantly reduced model fit (see Table 3). Specifically, among those who did not screen therapists, the presence of more frequent exemplary practices was associated with higher ratings of therapists helpfulness, $b = 0.51$, $p = .002$, whereas among those who did screen therapists, the presence of exemplary practices was not uniquely associated with ratings of therapists helpfulness, $b = 0.06$, $p = .54$. Conversely, the presence of inappropriate practices was not associated with ratings of therapists helpfulness for those who did not screen their therapists, $b = -0.16$, $p = .28$, whereas for those who did screen therapists, the presence of inappropriate practices was uniquely associated with reduced ratings of therapist helpfulness, $b = -0.28$, $p = .008$.

Unlike ratings of therapist helpfulness, screening had no moderating effect on the associations between therapeutic practices and premature termination (see also Table 3). However, screening groups experienced exemplary and inappropriate practices to a significantly different degree. Specifically, those who screened found therapists who used exemplary practices more frequently, $\alpha = 0.99$, $p < .001$, and inappropriate practices less frequently, $\alpha = -0.73$, $p = .001$, compared to therapists who were not screened.

Thematic Analysis of Helpful and Harmful Therapeutic Practices

Sixty percent of the participants provided responses to our invitation to describe (in an open format) what their therapist did that they found *very helpful*, while 38% provided responses to what they found *very unhelpful*. Those participating identified, on average, 1.44 very helpful

practices and 1.28 very unhelpful practices, respectively. Coders had agreement on 94% of the cases when independently classifying major/minor theme responses. Percentages reported for major/minor themes do not total 100% because many respondents mentioned more than one practice in their response (e.g., "accepted my lifestyle and offered practical advice").

The *very helpful practices* were coded into four major themes (*Affirming, Helpful Techniques, Nonjudgmental,* and *Knowledgeable*) and 23 minor themes (see Table 4) while the *very unhelpful practices* were coded into five major themes (*Judgmental, Pathologize, Knowledge, Dismissive, Focus*) and nineteen minor themes (see Table 5). The major themes represent broad categories while the minor themes represent more specific practices. The most frequently endorsed helpful practices were: 1) supporting the clients' identity/decisions regarding CNM, 2) acting nonjudgmental toward the client about CNM, 3) normalizing/not over-reacting about CNM, 4) prioritizing the client's needs/goals/values, and 5) asking helpful questions. The most frequently endorsed unhelpful practices were 1) indicating that CNM was the cause or result of another problem, 2) lacking or refusing to gather information about CNM, 3) being generally judgmental toward CNM, 4) indicating that CNM was wrong or not ideal, and 5) putting pressure on a client to end a relationship or come out.

Discussion

Given the stigma directed toward CNM (Conley, Moors et al., 2013) as well as the public's (growing) interest in these relationships (Haupert, Gesselman et al., 2017; Moors, 2017), the present study examined CNM client perceptions of general practices—some exemplary, some inappropriate—that therapists adopt when interacting with CNM clients. Our descriptive data suggests cause for cautious optimism, as exemplary practices were more commonly reported than inappropriate practices, though there is clear room for improvement in both areas.

We also tested a model grounded in a minority stress perspective, which examined the extent to which CNM clients' experiences with therapists using exemplary and/or inappropriate practices were linked to important therapeutic outcomes. As expected, CNM clients interacting with therapists who frequently engaged in inappropriate practices felt worse about their therapy experience while interacting with a therapist who used more exemplary practices was associated with CNM clients reporting that their therapy experience was helpful. Clients who screened their therapists also reported experiencing more exemplary and fewer inappropriate therapy practices, and rated their therapists as more helpful. Screening, however, was also associated with higher expectations of therapist conduct and greater disappointment if these expectations were violated.

Finally, open-ended responses revealed that CNM therapy clients find it particularly helpful when their therapist takes an affirming and nonjudgmental posture toward CNM as well as if their therapist is educated about and/or willing to gather information about CNM. Conversely, many CNM clients found it especially unhelpful when their therapists lacked knowledge about CNM and held judgmental, pathologizing, or dismissive attitudes toward CNM.

Taken together, the therapists whom CNM clients find helpful and maintain a therapeutic relationships with tend to be those who: (1) educate themselves about CNM issues; (2) hold affirming, nonjudgmental attitudes toward CNM; (3) help their clients feel good about being CNM; (4) remain open to discussing issues related to a client's relationship structure when brought up by their client, and (5) use helpful techniques that align with their CNM clients' goals. Therapists whom CNM clients perceive as unhelpful and tend to dissolve the therapeutic relationship early are those who (1) lack or refuse to gather information about CNM, and/or hold (2) judgmental, (3) pathologizing, and/or (4) dismissive attitudes toward CNM. Though an initial

glimpse of CNM clients' experiences in the therapeutic context, we believe that results of our investigation provide important implications for research related to sexual minority stress and diverse intimate partnerships. The current study also highlights promising avenues for improving therapist education and training, as well as future research on the therapy experiences of people who do not adhere to the societal ideals of monogamy.

Implications for Minority Stress

The minority stress framework posits that unique stigma-related stress renders sexual minorities more vulnerable to general psychological processes that are known to predict mental health issues (Hatzenbuehler, 2009). Therapists can either serve their CNM clients as bulwarks of support or, conversely, (in)advertently subject their CNM clients to stigma and discrimination. In the latter case, our data collectively suggests that therapist-perpetuated CNM stigma may be damaging the therapeutic alliance and jeopardizing the longevity of the therapeutic relationship for a number of CNM therapy clients, both of which are well-established correlates of poor mental health outcomes (Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000).

Given the uniquely privileged access therapists have to clients' moments of vulnerability, psychotherapy might be an especially important context for studying minority stress processes. Indeed, research on the basic need of belonging (see Baumeister & Leary, 1995; MacDonald & Leary, 2005) suggests that rejection is often most painful coming from sources with whom an individual is emotionally close (Kross, Berman, Mischel, Smith, & Wager, 2011). People engaged in CNM—who already face considerable stigma and discrimination—may therefore be particularly vulnerable to (un)supportive therapy practices.

One of the most notable and concerning findings of the current study is how frequently clients perceived their therapists to be suggesting or implying that CNM was the cause or result

of CNM clients' presenting concern. This appears to be a clear example of how therapists' lack of information or self-awareness about their bias appears to be harming CNM therapy clients. Rather than acknowledging how societal stigma may be causing or amplifying the problem, some therapists appear to be implying that CNM is the problem. Given this finding, we encourage therapists to examine how individuals engaging in CNM relationships are often forced to negotiate monocentric systems (e.g., societal monogamy ideals, institution of marriage) that pathologize them, which may be generating or contributing to their distress. Monogamous privilege and CNM stigma are so pervasive that the effects may not be evident to the client. CNM and monogamous therapy clients alike are expected to hold varying degrees of internalized mononormativity (internalization of negative messages about non-monogamy; Klesse, 2016), and therapists would ideally be prepared to help clients recognize the impact of mononormativity on their own attitudes toward their non-monogamous inclinations. Internalized mononormativity is a topic that remains largely unexplored and merits further investigation.

Improving Therapist Education and Training

The results from our investigation highlight the importance of therapists holding affirming, nonjudgmental attitudes toward CNM as well as the need for additional education and training for therapists. Though exemplary practices were the most commonly reported, our data suggest there remains room to increase the frequency of these practices. Moreover, our results show that inappropriate practices—reported in as many as one-third of cases—uniquely drive premature termination of therapeutic relationships, however, these inappropriate practices appear to be more heterogeneous in their relationship to their underlying latent factor.

The three most commonly reported inappropriate practices in our quantitative data (mistakenly assuming a client is monogamous, lacking CNM knowledge, and not being

supportive of CNM), in particular, have notably high rates of occurrence. Furthermore, the latter two inappropriate practices are especially strong indicators of generally unhelpful—and potentially iatrogenic—therapy practices. Routinely including CNM in continuing education and training programs would directly address the first two inappropriate practices by increasing awareness of CNM and providing helpful information needed to support CNM clients. This information would also likely combat (some of) the stigmatizing attitudes and/or lack of information prompting therapists to be unsupportive. The need for therapist education/training about CNM was also reinforced in our qualitative data. Nearly one in five participants (who chose to respond to these questions), commented on how helpful it was when their therapist was educated about CNM. One in five also mentioned how unhelpful it was that their therapist lacked education about CNM. In light of these findings, therapists could seek further education on CNM and display symbols of CNM affirmation (akin to showing support for LGBT identities). In addition, therapists could check in with CNM clients about their prior experiences with mental health systems given how frequently CNM clients have negative experiences with therapists.

Moving toward an inclusive model of sexuality and therapist practice, we should reflect on why so few therapists are receiving training on relationship diversity issues as well as the impact this therapist knowledge gap. Several strides have been made to provide therapists evidence-based resources for working with CNM clients (e.g., Schechinger, 2017a; Weitzman, Davidson, & Phillips, 2012). Further support by national organizations may be helpful to mobilize these efforts. As one example, the newly formed American Psychological Association Division 44 Consensual Non-Monogamy Task Force aims develop resources and training to promote awareness and inclusion of CNM relationships.

Finally, future research and advocacy initiatives should consider improving access to CNM-affirming therapists. CNM therapy clients who screened for a CNM-affirming therapist had better treatment outcomes as they reported experiencing more exemplary and fewer inappropriate therapy practices, and found their therapists to be more helpful than those who did not screen. Screening for a CNM-affirming therapist was also associated with higher expectations of therapist conduct and, likewise, greater disappointment if these expectations were violated. This finding highlights the importance of therapist education and creating avenues for CNM clients to find therapists who have been adequately educated about CNM. One way to improve visibility of therapists who are knowledgeable and affirming of CNM is to allow therapists to indicate consensual non-monogamy (polyamory, open relationships) as a population they specialize in on popular therapist locator websites (e.g., Psychology Today and APA Psychologist Locator)

Future Research

Replication of our observed effects using high-powered longitudinal designs would be helpful to address concerns of the robustness of our findings (see Tackett et al., in press). Assessments of within-therapist variability as well as predictors of within-therapist and between-therapist variability in practice usage with CNM clients is also a critical next step in determining the scope of needed training reform. The current study also focused on global therapist helpfulness and exploring with more nuanced measures of therapist helpfulness over time is another needed step for moving research in this domain forward. Additional studies investigating the impact of CNM stigma and therapy practices on mental health and motivation for (current and future) treatment are also needed. Collectively, this research would help build the scientific

foundation needed to create empirically informed guidelines for psychological practice with clients engaged in CNM.

Guidelines for psychological practice. Understanding the differences and similarities among people engaging in a variety of stigmatized relationships, identities, and practices could also help uncover additional exemplary (and inappropriate) therapy practices. Further research into points of convergence and divergence with the CNM and LGB populations is warranted given the many forms of convergence shared between these communities. For example, both communities appear to experience coming out/visibility management, marital/adoption/custody/parental participation issues, moral ground discrimination, extended family consequences, negative internalizations from minority stress, difficulty finding community/fitting in, and housing/workplace discrimination. The treatment guidelines created for LGB clients (APA, 2012) therefore may help inform practices guidelines for working with CNM clients. Separate practice guidelines are needed, however, to address the issues that are unique to CNM. Issues related to jealousy management and integrating new partners, for example, are likely to be more salient for the CNM community. Certain processes are also likely to be experienced quite differently (e.g., coming out as non-monogamous is different than coming out as lesbian, bi, gay, queer, etc.). The current paper highlights the need and provides an empirical foundation for CNM clinical practice guidelines.

Include relationship structure on demographic forms. In light of the frequency that CNM therapy clients were incorrectly assumed to be monogamous, it is recommended that mental health professionals/organization inquire about relationship structure on their demographic form. In addition to reducing the frequency of mis-identifying CNM therapy clients, asking clients to disclose their relationship structure on demographic forms is encouraged

because doing so may: (1) provide data to determine how well therapists are serving their CNM clients and how professional conduct might be improved; (2) create a safer avenue for disclosure; (3) signal that a site/clinician is at least aware of CNM; (4) promote in-session discussion/disclosure; (5) validate CNM client's experience/identity; and (6) raise awareness among staff and non-CNM clients (Schechinger, 2017b). As awareness of CNM grows, we anticipate that an increasing number of therapists and mental healthcare organizations will demonstrate greater inclusivity of relationship diversity by inquiring about relationship structure—a step recently taken by all ten of the counseling centers in the University of California system[3].

Limitations

Our study was limited in several key respects. First, our cross-sectional retrospective design required all participants to recall their therapeutic experiences. Though we focused our analyses on participants' remembrances of their most recent therapist in order to reduce possible recall bias, future research would benefit from a more intensive daily design, in which participants could report on their therapeutic experiences with less opportunity to later forget important details or (re)construct a different sense of meaning from therapeutic sessions.

Our study was also limited in the use of a single-item indicator of perceived therapist helpfulness. While our chosen single item measure is a face valid indicator of client's experience

[3] The following item, created in conjunction with national CNM experts and community leaders, was added to the standardized questionnaire: *When it comes to relationships, I think of myself or identify as: Non-monogamous (Polyamory, Open relationship, etc.); Monogamous; Questioning; Other; Prefer not to answer*

in therapy, moving forward it would be beneficial to use a more nuanced multidimensional measure of participant's affective experiences in therapy, in order to identify, specifically, what features of therapist-perception are influenced by exemplary and inappropriate practices.

The current study also was not a random or representative sample. Moreover, compared to other CNM studies, the current study appears to have higher representation from individuals identifying as bisexual and pansexual/omnisexual/queer and lower representation from individuals identifying as lesbian or gay. This may be due (in part) to providing pansexual/omnisexual/queer as an identification option. The generalizability of our study is also limited by the fact that our sample was drawn primarily from those who are/were involved in online forums/communities for CNM relationships. While we asked participants to respond regarding their relationship structure/orientation, we do not address the extent their experiences may have been moderated by other aspects of their identity (e.g., race, sexual orientation, gender). We also did not collect data directly from therapists, but given that nearly half of our participants (48%) screened for CNM-affirming therapists, we therefore think that if anything, our sample may be under-reporting rates of non-affirming practices.

Another limitation of the current study is the targeted recruitment strategy which focused on the CNM community as a whole (as opposed to specific CNM practices, agreements, or labels such as polyamorous, open, swinging). Thus, it remains possible that certain effects might be moderated by CNM relationship "subtypes" or therapy modality. For example, Matsick and colleagues (2014) found that polyamorous relationships are perceived more favorably than swinging and open relationships. We also did not specify the type of therapy participants were receiving (e.g., individual or couples/partners therapy), which also could serve as a moderator for given effects.

Conclusion

People engaged in polyamory, swinging, open, and non-labeled CNM relationships represent a growing and, potentially, under-appreciated population accessing therapy. Similar to people in monogamous relationships, people in CNM relationships may seek out clinical services to gain support in navigating their romantic and sexual relationships. Or, like members of other sexual and gender minority groups, people in CNM relationships may seek out mental health services to endure the stigma and discrimination that they face. Mental health providers are, therefore, positioned to serve a valuable role in promoting the well-being of these individuals. However, our research suggests that therapists are not sufficiently knowledgeable about CNM relationships, and that this lack of knowledge—and possible prejudices held towards individuals in CNM relationships—can add to the minority stress experienced by these clients. We encourage additional research, training, and the development of standardized guidelines for psychological treatment of individuals in CNM relationships to better serve the diverse sexual and relational constituencies seeking mental health services.

References

American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist, 67*(1), 10-42. doi: 10.1037/a0024659

Anapol, D. (2010). *Polyamory in the 21st Century*. Lanham, MD: Rowman & Littlefield.

Aviram, H., & Leachman, G. (2015). The future of polyamorous marriage: Lessons from the marriage equality struggle. *Harvard Journal of Law & Gender*, 38, 269-336. http://dx.doi.org/10.2139/ssrn.2485853

Bairstow, A. (2016). Couples exploring non-monogamy: Guidelines for therapists. *Journal of Sex & Marital Therapy*, *43*(4), 343-353. doi: 10.1080/0092623X.2016.1164782

Balsam, K. F., Rothblum, E. D., & Beauchaine, T. P. (2005). Victimization over the life span: A comparison of lesbian, gay, bisexual, and heterosexual siblings. *Journal of Consulting and Clinical Psychology, 73(3)*, 477-487. doi: 10.1037/0022-006X.73.3.477

Barker, M. (2005). This is my partner, and this is my. . . partner's partner: Constructing a polyamorous identity in a monogamous world. Journal of Constructivist Psychology, 18, 75–88. https://doi.org/10.1080/10720530590523107

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin, 117*(3), 497-529. http://dx.doi.org/10.1037/0033-2909.117.3.497

Beaujean, A. A. (2014). *Latent variable modeling using R: A step-by-step guide.* New York, NY: Routledge.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. http://dx.doi.org/10.1191/1478088706qp063oa

Brewster, M. E., Soderstrom, B., Esposito, J., Breslow, A., Sawyer, J., Geiger, E., . . . Foster, A. (2017). A content analysis of scholarship on consensual nonmonogamies: Methodological roadmaps, current themes, and directions for future research. *Couple and Family Psychology: Research and Practice, 6*(1), 32-47.

Brown, T. A. (2015). *Confirmatory factor analysis for applied research* (2nd ed.). New York, NY: Guilford Press.

Browning, C., Reynolds, A. L., & Dworkin, S. H. (1991). Affirmative psychotherapy for lesbian women. *Counseling Psychologist, 19*(2), 177-196. 10.1177/0011000091192004

Cheung, G. W., & Rensvold, R. B. (2002). Evaluating goodness-of-fit indexes for testing measurement invariance. *Structural Equation Modeling, 9*, 233-255. doi: 10.1207/S15328007SEM0902_5.

Cochran, S. D. (2001). Emerging issues in research on lesbians' and gay men's mental health: Does sexual orientation really matter? *American Psychologist, 56(11),* 931-947. http://dx.doi.org/10.1037/0003-066X.56.11.931

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71(1)*, 53-61. http://dx.doi.org/10.1037/0022-006X.71.1.53

Conley, T. D., Matsick, J., Valentine, B., Moors, A. C., & Ziegler, A. (2017). Investigation of consensually non-monogamous relationships: Theories, methods and new directions. *Perspectives on Psychological Science, 12(2)* 205-232. https://doi.org/10.1177/1745691616667925

Conley, T. D., Moors, A. C., Matsick, J. L., & Ziegler, A. (2013). The fewer the merrier: Assessing stigma surrounding non-normative romantic relationships *Analyses of Social Issues and Public Policy, 13*(1), 1-30. 10.1111/j.1530-2415.2012.01286.x

Conley, T. D., Ziegler, A., Moors, A. C., Matsick, J. L., & Valentine, B. (2013). A critical examination of popular assumptions about the benefits and outcomes of monogamous relationships. *Personality and Social Psychology Review, 17*(2), 124-141. https://doi.org/10.1177/1088868312467087

Conte, H. R., Buckley, P., Picard, S., & Karasu, T. B. (1994). Relations between satisfaction with therapists and psychotherapy outcome. *Journal of Psychotherapy Practice and Research, (3)*3, 215-221.

Corey, G., Schneider-Corey, M., & Callanan, P. (1993). *Issues and ethics in the helping professions* (4th ed.). Belmont, CA: Brooks/Cole.

Cox, D. W., Fleckenstein, J., & Bergstrand, C. R. (2013). What do polys want? An overview of the 2012 Loving More survey. *Loving More Magazine*.

DiPlacido, J. (1998). Minority stress among lesbians, gay men, and bisexuals: A consequence of heterosexism, homophobia, and stigmatization. In G. M. Herek (Ed.), *Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals* (pp. 138-159). Thousand Oaks, CA: Sage.

Eisenberg, M. E., & Resnick, M. D. (2006). Suicidality among gay, lesbian and bisexual youth: The role of protective factors. *Journal of Adolescent Health, 39(5),* 662-668. https://doi.org/10.1016/j.jadohealth.2006.04.024

Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology,* 32, 307-322. doi:10.1037/0022-0167.32.3.307

Emens, E.F. (2004). Momogamy's law: Compulsory monogamy and polyamorous existence. *New York University Review of Law & Social Change. 29*(58): 277–376. http://dx.doi.org/10.2139/ssrn.506242

Eubanks-Carter, C., Burckell, L. A., & Goldfried, M. R. (2005). Enhancing therapeutic effectiveness with gay, lesbian, and bisexual clients. *Clinical Psychology: Science and Practice, 12,* 1–18. doi:10.1093/clipsy.bpi001

Feldman, N. (2016). *Polygamy is the next marriage-rights frontier.* Retrieved from http://www.bloombergview.com/articles/2016-04-13/polygamy-is-the-next-marriage-rights-frontier

Finch, W. H., & French, B. F. (2015). *Latent variable modeling with R.* New York, NY: Routledge.

Fridman, A. (2010). Client-rated helpfulness of two approaches for addressing religious concerns in therapy (Order No. 3422135). Available from ProQuest Dissertations & Theses A&I; ProQuest Dissertations & Theses Global. (756739653). Retrieved from https://search.proquest.com/docview/756739653?accountid=14496

Fuller, F., & Hill, C. E. (1985). Counselor and helpee perceptions of counselor intentions in relation to outcome in a single counseling session. *Journal of Counseling Psychology, 32*(3), 329-338. http://dx.doi.org/10.1037/0022-0167.32.3.329

Garnets, L., Hancock, K. A., Cochran, S. D., Goodchilds, J., & Peplau, L. A. (1991). Issues in psychotherapy with lesbians and gay men. *American Psychologist, 46,* 964-972. doi:10.1037/0003-066x.46.9.964

Girard, A., & Brownlee, A. (2015). Assessment guidelines and clinical implications for therapists working with couples in sexually open marriages. *Sexual and Relationship Therapy, 30*(4), 462-474. http://dx.doi.org/10.1080/14681994.2015.1028352

Graham, N. (2014). Polyamory: A call for increased mental health professional awareness. *Archives of Sexual Behavior*, *43*(6), 1031-1034. doi: 10.1007/s10508-014-0321-3

Grunt-Mejer, K., & Campbell, C. (2016). Around consensual nonmonogamies: Assessing attitudes toward nonexclusive relationships. *The Journal of Sex Research, 53*(1), 45-53.

Hancock, G. R., & Mueller, R. O. (2011). The reliability paradox in assessing structural relations within covariance structure models. *Educational and Psychological Measurement, 71*, 306-324.

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135(5)*, 707-730. http://dx.doi.org/10.1037/a0016441

Haupert, M., Gesselman, A. N., Moors, A. C., Fisher, H., & Garcia, J. R (2017). Prevalence of experiences with consensual nonmonogamous relationships: Findings from two national samples of single Americans. *Journal of Sex & Marital Therapy, 43*(5), 424-440. http://dx.doi.org/10.1080/0092623X.2016.1178675

Haupert, M., Moors, A. C., Gesselman, A. N., & Garcia, J. R. (2017). Estimates and correlations of experiences with consensually non-monogamous relationships. *Current Sexual Health Reports, 9*(3), 155-165.

Heilbrun, A. B. (1982). Cognitive factors in early counseling termination: Social insight and level of defensiveness. *Journal of Counseling Psychology, 29*(1), 29-38. doi:10.1037/0022-0167.29.1.29

Henrich, R., & Trawinski, C. (2016). Social and therapeutic challenges facing polyamorous clients. *Sexual and Relationship Therapy*, *31*(3), 376-390. http://dx.doi.org/10.1080/14681994.2016.1174331

Hill, C. E., O'Grady, K. E., Balenger, V., Busse, W., Falk, D. R., Hill, M., ... & Taffe, R. (1994). Methodological examination of videotape-assisted reviews in brief therapy: Helpfulness ratings, therapist intentions, client reactions, mood, and session evaluation. *Journal of Counseling Psychology*, *41*(2), 236. http://dx.doi.org/10.1037/0022-0167.41.2.236

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61(4)*, 561-573. http://dx.doi.org/10.1037/0022-006X.61.4.561

Horvath, A. O., Marx, R. W., & Kamann, A. M. (1990). Thinking about thinking in therapy: An examination of clients' understanding of their therapists' intentions. *Journal of Consulting and Clinical Psychology*, 58(5), 614-621. doi:http://dx.doi.org/10.1037/0022-006X.58.5.614

Hoyt, W. T. (2002). Bias in participant ratings of psychotherapy process: An initial generalizability study. *Journal of Counseling Psychology, 49*(1), 35-46. http://dx.doi.org/10.1037/0022-0167.49.1.35

Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling*, *6*(1), 1-55. doi: 10.1080/10705519909540118

Hutzler, K. T., Giuliano, T. A., Herselman, J. R., & Johnson, S. M. (2016). Three's a crowd: Public awareness and (mis)perceptions of polyamory. *Psychology & Sexuality 7*(2), 69-87. http://dx.doi.org/10.1080/19419899.2015.1004102

Klesse, C. (2011). Notions of love in polyamory – Elements in a discourse on multiple loving. *Laboratorium 3*(2): 4–25. https://www.ceeol.com/search/article-detail?id=72863

Kross, E., Berman, M. G., Mischel, W., Smith, E. E., & Wager, T. D. (2011). Social rejection shares somatosensory representations with physical pain. *Proceedings of the National Academy of Sciences, 108*(15), 6270-6275. doi: 10.1073/pnas.1102693108

Lano K., & Parry-Lano, C. (1995). *Breaking the Barriers to Desire*. Nottingham: Five Leaves Publications. doi: 0907123368

Levine, E. C., Herbenick, D., Martinez, O., Fu, T., & Dodge, B. (2018). Open relationships, nonconsensual nonmonogamy, and monogamy among U.S. adults: Findings from the 2012 National Survey of Sexual Health and Behavior. *Archives of Sexual Behavior, 47*, 1439-1450. doi: 10.1007/s10508-018-1178-7

Levitt, H. M., & Williams, D. C. (2010). Facilitating client change: Principles based upon the experience of eminent psychotherapists. *Psychotherapy Research*, *20*(3), 337-352. http://dx.doi.org/10.1080/10503300903476708

Liddle, B. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings of helpfulness by gay and lesbian clients. *Journal of Counseling Psychology, 43*(4), 394-401. doi:10.1037/ 0022-0167.43.4.394

Little, T. D. (2013). *Longitudinal structural equation modeling*. New York, NY: Guilford Press.

MacDonald, G., & Leary, M. R. (2005). Why does social exclusion hurt? The relationship between social and physical pain. *Psychological Bulletin*, *131*(12), 202-223. http://dx.doi.org/10.1037/0033-2909.131.2.202

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438-450. http://dx.doi.org/10.1037/0022-006X.68.3.438

Matsick, J. L., Conley, T. D., Ziegler, A., Moors, A. C., & Rubin, J. D. (2014). Love and sex: Polyamorous relationships are perceived more favourably than swinging and open relationships. *Psychology & Sexuality*, *5*(4), 339-348. https://doi.org/10.1080/19419899.2013.832934

McCoy, M. A., Stinson, M. A., Ross, D. B., & Hjelmstad, L. R. (2015). Who's in our clients' bed? A case illustration of sex therapy with a polyamorous couple. *Journal of Sex & Marital Therapy*, *41*(2), 134-144. doi: 10. 1080/0092623X.2013.864366

McNeish, D., An, J., & Hancock, G. R. (2018). The thorny relationship between measurement quality and fit index cutoffs in latent variable models. *Journal of Personality Assessment*, *100*, 43-52.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129(5),* 674-697. doi: 10.1037/0033-2909.129.5.674

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity, 2(3),* 209-213. doi: 10.1037/sgd0000132

Mikalson, P., Pardo, S., & Green, J. (2012). *First do no harm: Reducing disparities for lesbian, gay, bisexual, transgender, queer, and questioning populations in California.* Retrieved from http://www.eqcai.org/atf/ cf/%7B8cca0e2f-faec-46c1-8727-cb02a7d1b3cc%7D/FIRST_DO_NO_ HARM-LGBTQ_REPORT.PDF

Moors, A. C. (2017). Has the American public's interest in relationships beyond "the couple" increased over time? *Journal of Sex Research, 54*(6), 677-684. doi: 10.1080/00224499.2016.1178208

Moors, A. C., Matsick, J., & Schechinger, H. A. (2017). Unique and shared relationship benefits of consensually non-monogamous and monogamous relationships: A review and insights for moving forward. *European Psychologist, 22*(1), 55-71. https://doi.org/10.1027/1016-9040/a000278

Moors, A. C., & Schechinger, H. A. (2014). Understanding sexuality: implications of Rubin for relationship research and clinical practice. *Sexual and Relationship Therapy, 29(4),* 476-482. http://dx.doi.org/10.1080/14681994.2014.941347

Nichols, M., & Shernoff, M. (2007). *Therapy with sexual minorities: Queering practice.* In S. R. Leiblum (2007), *Principles and practice of sex therapy (4th ed.),* 379-415. New York, NY, US: Guilford Press.

Pekarik, G. (1992). Relationship of clients' reasons for dropping out of treatment to outcome and satisfaction. *Journal of Clinical Psychology, 48*(1), 91-98. doi: 10.1002/1097-4679(199201)48:1<91::AID-JCLP2270480113>3.0.CO;2-W

Perez, R. M., Debord, K. A., & Bieschke, K. J. (EDS.). (2000). *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients.* Washington, DC: American Psychological Association.

Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: the impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of Personality and Social Psychology, 97(4)*, 634-651. http://dx.doi.org/10.1037/a0015815

R Core Team. (2016). *R: A language and environment for statistical computing.* Vienna, Austria: R Foundation for Statistical Computing.

Rosseel, Y. (2012). lavaan: An R package for structural equation modeling. *Journal of Statistical Software, 48*(2), 1-36. doi: 10.18637/jss.v048.i02

Rubel, A. N., & Bogaert, A. F. (2015). Consensual nonmonogamy: Psychological well-being and relationship quality correlates. *The Journal of Sex Research, 52*(9), 961-982. http://dx.doi.org/10.1080/00224499.2014.942722

Rubin, J. D., Moors, A. C., Matsick, J. L., Ziegler, A., & Conley, T. D. (2014). On the margins: Considering diversity among consensually non-monogamous relationships. *Journal für Psychologie, 22*(1), 19-37.

Safren, S. A., & Heimberg, R. G. (1999). Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology, 67(6),* 859-866.

Satorra, A. (2000). Scaled and adjusted restricted tests in multi-sample analysis of moment structures. In R. D. H. Heijmans, D. S. G. Pollock, & A. Satorra (Eds.), *Innovations in multivariate statistical analysis: A Festschrift for Heinz Neudecker* (pp. 233-247). London, UK: Kluwer Academic Publishers.

Schechinger, H. A. (2017a). *Room for three (or more): How to create a poly-affirming practice.* Webinar hosted by APA Division 44 Bisexual Issues Committee.

Schechinger, H. A. (2017b, July 1). Toward inclusive science and practice: Here's what you need to know about consensually non-monogamous relationships. *American Psychological Association Division 44 Newsletter, July 2017, 1-4.* Retrieved from http://www.apadivisions.org/division-44/publications/newsletters/division/2017/06/non-monogamy.aspx

semTools Contributors. (2016). *semTools: Useful tools for structural equation modeling*. Retrieved from https://CRAN.R-project.org/package=semTools.

Sheff, E. (2015). *Polyamorists next door: Inside multiple-partner relationships and families*. Lanham, MD: Rowman & Littlefield.

Stein, E. (2015). *Plural marriage, group marriage, and immutability in Obergefell v. Hodges and beyond.* Paper presented at the Symposium on The Implications of Obergefell v. Hodges for Families, Faith, and the Future, Provo, Utah.

Tackett, J. L., Lilienfeld, S. O., Patrick, C. J., Johnson, S. L., Krueger, R. F., Miller, J. D., Oltmanns, T. F., & Shrout, P. E. (in press). It's time to broaden the replicability conversation: Thoughts for and from clinical psychological science. *Perspectives on Psychological Science*.

Taormino, T. (2008). *Opening up: A guide to creating and sustaining open relationships*. San Francisco: Cleis Press.

Thompson, A., Bagley, A. J., & Moore, E. A. (2018). Young men and women's implicit attitudes towards consensually nonmonogamous relationships. *Psychology & Sexuality*, *9*(2), 117-131. doi: 10.1080/19419899.2018.1435560

Tweedy, A. (2011) Polyamory as a sexual orientation. *University of Cincinnati Law Review. 79*(4): 1461–1515.

Vandenberg, R. J., & Lance, C. E. (2000). A review and synthesis of the measurement invariance literature: Suggestions, practices, and recommendations for organizational research. *Organizational Research Methods, 3*, 4-70.

Veaux, F., & Rickert, E. (2014). *More Than Two: A practical guide to ethical polyamory*: Thorntree Press, LLC.

Warner, M. (1999). *The trouble with normal: Sex, politics, and queer ethics.* New York: Simon and Schuster.

Weitzman, G. (2006). Therapy with clients who are bisexual and polyamorous. *Journal of Bisexuality, 6*(1), 137-164. doi:10.1300/J159v06n01_08

Weitzman, G., Davidson, J., & Phillips Jr., R. A. (2012). What psychology professionals should know about polyamory. *National Coalition for Sexual Freedom.* Retrieved from http://instituteforsexuality.com/wp-content/uploads/2014/05/What-therapists-should-know-about-Polyamory-1.pdf

Wickham, H. (2009). *ggplot2: Elegant graphics for data analysis*. New York, NY: Springer-Verlag.

Xavier, J. M. (2000). *The Washington, DC Transgender Needs Assessment Survey.* Washington, DC: Us Helping Us, People Into Living. Retrieved from http://www.glaa.org/archive/2000/tgneedsassessment1112.shtml

Zimmerman, K. J. (2012). Clients in sexually open relationships: Considerations for therapists. *Journal of Feminist Family Therapy: An International Forum, 24*(3), 272-289. doi:http://dx.doi.org/10.1080/08952833.2012.648

Table 1

Demographics of Final Sample

Demographic Information	% or *M* (*SD)*
Age	36.62 (10.40)
Gender	
Woman	62.25%
Man	24.90%
Another term best described gender identity (e.g., gender queer, trans)	10.04%
Sexual Orientation	
Bisexual	43.37%
Straight	25.70%
Gay or Lesbian	1.20%
Pansexual/Omnisexual/Queer	26.91%
Race/Ethnicity	
African American/Black	1.20%
Asian American	0.04%
European American/White	82.73%
Latino/Latina	0.08%
Native American	0.04%
Multi-Racial	6.02%
Another term best described racial-ethnic identity	5.62%
Relationship Type	
Open Relationship/Marriage	8.43%
Swinging/In the "Lifestyle"	1.20%
Polyamory	78.71%
Another term best described consensually non-monogamous arrangement (e.g., monogamish) or specifically non-labeled	11.65%

Table 2

Exemplary and Inappropriate Therapeutic Practices Descriptions and Frequencies among CNM Clients (Adapted from Liddle, 1996) and their Loadings from a Confirmatory Two-Factor Solution

Practice	Factor	Item Label	Loading (λ)
Your therapist was quite knowledgeable about consensual non-monogamy communities and other resources (so that he or she could have put you in touch with useful books or important community resources).	Exemplary	CNMKnowledge	.72
Your therapist was not afraid to deal with your relationship orientation when it was relevant.	Exemplary	NotAfraidOfCNM	.93
Your therapist helped you feel good about yourself as a consensually non-monogamous person.	Exemplary	HelpedFeelGoodAboutCNM	.84
Your therapist gave some indication that he or she had assumed you were monogamous, before you indicated your relationship orientation.	Inappropriate	AssumeMono	.72
Your therapist indicated that he or she believed that non-monogamy is bad, sick, or inferior.	Inappropriate	CNMBad	1.00
Your therapist discounted, argued against, or pushed you to renounce your non-monogamous lifestyle/identity.	Inappropriate	DemandRenounceCNM	.94
Your therapist blamed your problems on your relationship orientation or insisted on focusing on your relationship orientation without evidence that your relationship orientation was relevant to your problems.	Inappropriate	BlamedCNM	.97
Your therapist suddenly refused to see you any more after you disclosed your relationship orientation. (Do not include cases where your therapist made a sensitive and appropriate referral to a therapist who was especially skilled in your expressed area of concern).	Inappropriate	RefusedTreatment	.35

Your therapist lacked the basic knowledge of consensual non-monogamy issues necessary to be an effective therapist for you and/or you had to be constantly educating him or her about these issues.	Inappropriate	LackedCNMKnowledge	.86
Your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky.	Inappropriate	PressuredToComeOut	.33
Your therapist did not recognize the importance of consensual non-monogamous relationships and/or did not appropriately support these relationships.	Inappropriate	NotSupportCNM	.91
Your therapist did not understand the problems of societal prejudice against consensually non-monogamous individuals.	Inappropriate	NotUnderstandCNMPredj	.73
Your therapist made an issue of your relationships orientation even when it was not relevant.	Inappropriate	MadeIssueOfCNM	.92

All factor loadings significant at the $p < .001$ level.

Table 3

Fit Indexes from Measurement Invariance and Structural Models Comparing Participants Who Did (n = 114) and Did Not (n = 135) Screen Prospective Therapists for CNM Competency

Model	χ^2	df	$\Delta\chi^2$ (Δdf)	RMSEA	CFI	ΔCFI
Configural Invariance	177.81*	146	--	.04	.989	--
Weak Invariance	215.05**	158	10.88* (2.95)	.05	.980	.009
Strong Invariance	208.48**	157	6.78 (4.13)	.05	.982	-.002
Equated Latent Slopes: Helpfulness	226.62***	160	8.69** (1.38)	.06	.976	.004
Equated Latent Slopes: Termination	211.27**	160	0.06 (0.65)	.05	.982	-.002
Equated Latent Means	259.83***	159	18.13*** (1.14)	.07	.964	.018

*p < .05. ** p < .01. *** p < .001

Table 4

Very helpful practices: Major/minor themes for qualitative data and percentages.

Major Themes	%	Example Responses	Minor Themes	%
Affirming	49	"Supportive of polyamory"	Supported CNM identity/decision	18
		"Focused on my needs, not who met them"	Prioritized client's needs/goals/values	10
		"Said CNM was valid"	Acknowledged CNM as valid	9
		"Trusted my decisions"	Validated/trusted clients decisions	8
		"Supportive of my developing bisexuality	Queer/kink affirming	3
			Acknowledged societal stigma	1
Helpful techniques	43	"Asked relevant questions."	Asked helpful questions	10
		"Offered practical advice."	Provided helpful advice	7
		"Helped us develop parameters."	Helped to improve/navigate relationships	7
			Listened effectively	7
		"Treated each relationship separately/respectfully."	Valued relationships individually	6
			Helped explore/manage emotions	5
			Didn't avoid or fixate on CNM	1
Nonjudgmental	36	"No judgments"	Was nonjudgmental	11
		"Not making a big deal out of non-monogamy."	Normalized/didn't over-react	11
			Was accepting	8
		"Apologized for making assumptions."	Acknowledged bias	3
		"Didn't think my issues were because I'm poly"	Didn't pathologize/blame CNM for problems	2
			Remained neutral	1
Knowledge	17	"Being familiar with non-monogamous issues."	Had basic knowledge of CNM	7
			Open to learn	5
		"Researched non-monogamy on her own."	Sought outside information	3
			Provided CNM resources	2

Note: % of participants = % of those who wrote responses that endorsed the theme.

Table 5

Very unhelpful practices: Major/minor themes for qualitative data and percentages.

Major Themes	%	Example Responses	Minor Themes	%
Judgmental	48	"Judging and moralizing."	Generally judgmental	11
		"That it was unnatural."	CNM is wrong or not ideal	10
		"Bringing up religion."	Emphasized religion/traditional values	7
		Judging with facial expressions."	Nonverbal judgment/discomfort	7
		"Had obvious issues with bisexuals and CNM."	Felt unsafe discussing CNM	4
			Queer critical (e.g., kink, bisexuality)	3
		"Called me a whore."	Criticized/shamed for being CNM	3
Pathologize	38	"Equating CNM to a commitment problem."	CNM is the cause or result of another problem	27
		"Insisting 'real' women want monogamy."	CNM harms relationships	6
			CNM is not good for women	4
Knowledge	19	"Failing to research CNM."	Lacked/refused to gather information about CNM	12
		"Didn't really understand non-monogamy."	Not listening/grasping CNM concerns	4
		"Expected me to educate them on my dollar."	Expected client to educate therapist	3
Dismissive	18	"Suggested I leave my bf because he's poly."	Pressured to end a relationship or come out	10
		"Refused to entertain CNM as an option."	Dismissed CNM	4
			Assumed monogamy	2
		"Assumed I am into monogamy."	Refused service	2
Focus	5	"Far too interested in sexual details of poly."	Focused on CNM too much	3
			Avoided CNM	2

Note: % of participants = % of those who wrote responses that endorsed the theme.

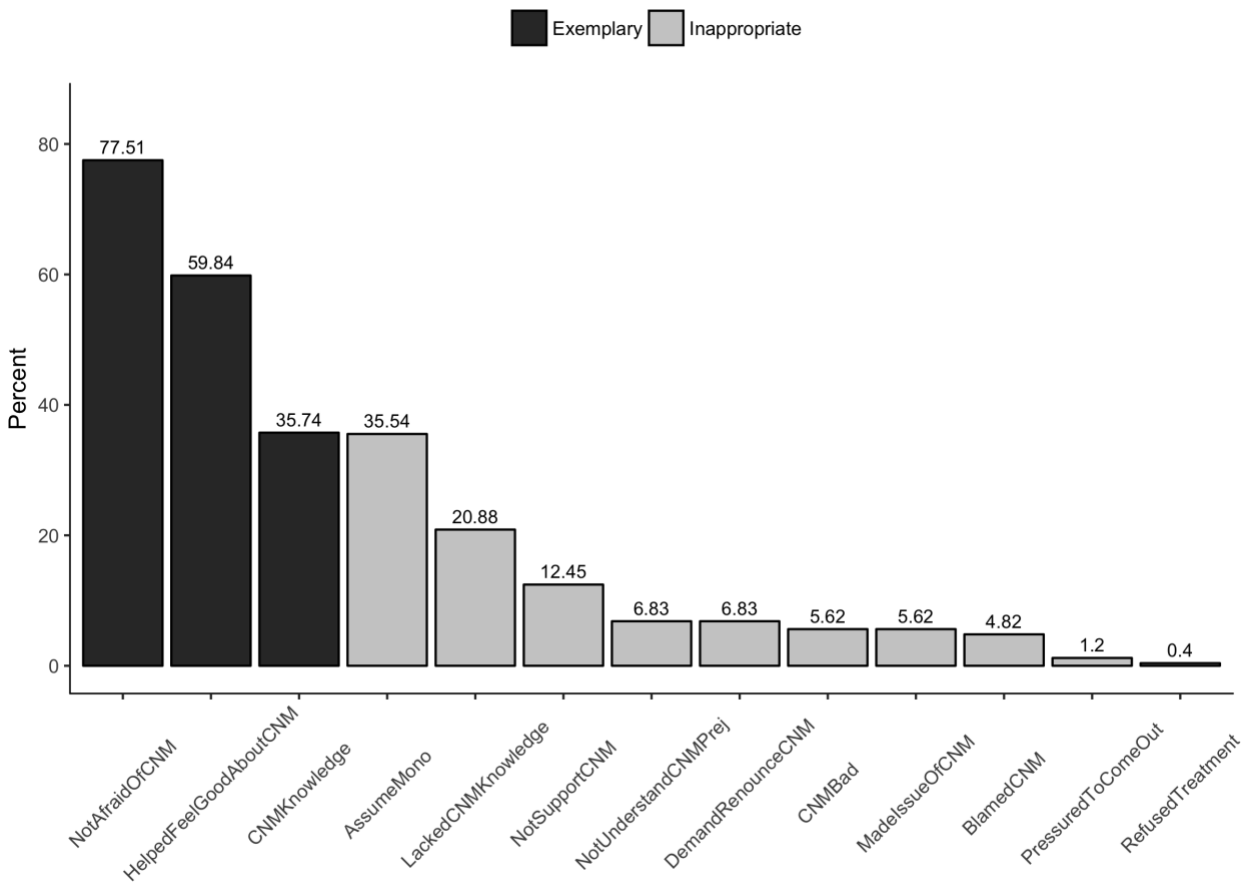

Figure 1. Frequency of perceived exemplary and inappropriate therapeutic practices used by most recent therapists, as reported by clients engaged in a CNM relationship.